IMPACT Plus
Parent to Parent
New Employee/Contract Screening Form

Applicant Name: _____ **Applicant Social Security #:** _____

Subprovider Name: _____ **Applicant Date of Birth:** _____

Supervisor's Name & Credentials (who will provide weekly face-to-face supervision): _____

Region(s) this applicant will be working: _____

Please complete the following information:

- ❑ Is this applicant a parent of a child who has a behavioral health disorder? _____
- ❑ If yes, has the child received at least one state-funded service for the child's disability? _____
- ❑ Has this applicant been approved by DMHMRS following completion of ten (10) hours of initial training provided or approved by DMHMRS?_____
- ❑ If yes, list month and year of completion? _____

All of the following boxes must be checked verifying applicable information for each section is included with this form. The Credentialing Committee will not review packets that do not contain all of the required information.

- ❑ Current Department for Community Based Services background check results
- ❑ Current Administrative Office of the Courts background check results
- ❑ Current Statement of Disclosure signed by applicant and subprovider

Comments: _____

In accordance with 907 KAR 3:030 and the IMPACT Plus Subprovider Agreement, the undersigned do hereby affirm all information related to this applicant has been reviewed for the Parent to Parent position. References and other documentation submitted have been verified and the undersigned attest to it's accuracy.

In addition, we understand this applicant must be reviewed by the IMPACT Plus Credentialing Committee located in Frankfort, KY, and given "Approval" status before the delivery of IMPACT Plus services can be considered for Medicaid reimbursement.

Subprovider's Signature _____
Name Position Date

Applicant's Signature _____
Name Position Date